

Out-of-Pocket Health Spending by Poor and Near-Poor Elderly Medicare Beneficiaries

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Objective. To estimate out-of-pocket health care spending by lower-income Medicare beneficiaries, and to examine spending variations between those who receive Medicaid assistance and those who do not receive such aid.

Data Sources and Collection. 1993 Medicare Current Beneficiary Survey (MCBS) Cost and Use files, supplemented with data from the Bureau of the Census (Current Population Survey); the Congressional Budget Office; the Health Care Financing Administration, Office of the Actuary (National Health Accounts); and the Social Security Administration.

Study Design. We analyzed out-of-pocket spending through a Medicare Benefits Simulation model, which projects out-of-pocket health care spending from the 1993 MCBS to 1997. Out-of-pocket health care spending is defined to include Medicare deductibles and coinsurance; premiums for private insurance, Medicare Part B, and Medicare HMOs; payments for non-covered goods and services; and balance billing by physicians. It excludes the costs of home care and nursing facility services, as well as indirect tax payments toward health care financing.

Principal Findings. Almost 60 percent of beneficiaries with incomes below the poverty level did not receive Medicaid assistance in 1997. We estimate that these beneficiaries spent, on average, about half their income out-of-pocket for health care, whether they were enrolled in a Medicare HMO or in the traditional fee-for-service program. The 75 percent of beneficiaries with incomes between 100 and 125 percent of the poverty level who were not enrolled in Medicaid spent an estimated 30 percent of their income out-of-pocket on health care if they were in the traditional program and about 23 percent of their income if they were enrolled in a Medicare HMO. Average out-of-pocket spending among fee-for-service beneficiaries varied depending on whether beneficiaries had Medigap policies, employer-provided supplemental insurance, or no supplemental coverage. Those without supplemental coverage spent more on health care goods and services, but spent less than the other groups on prescription drugs and dental care—services not covered by Medicare.

Conclusions. While Medicaid provides substantial protection for some lower-income Medicare beneficiaries, out-of-pocket health care spending continues to be a substantial burden for most of this population. Medicare reform discussions that focus on

shifting more costs to beneficiaries should take into account the dramatic costs of health care already faced by this vulnerable population.

Key Words. Out-of-pocket spending, Medicare, low income

Although Medicare has long guaranteed access to health insurance coverage to virtually all persons age 65 and older, gaps in Medicare coverage can create substantial financial burdens for some beneficiaries, particularly those with low incomes. Unlike many private health insurance programs, Medicare does not pay for outpatient prescription drugs or many preventive services. Moreover, Medicare's cost-sharing requirements are substantial,¹ and Medicare does not limit beneficiaries' total payments for cost sharing.

Previous studies have estimated the magnitude of out-of-pocket spending by older Americans. For example, Moon, Kuntz, and Pounder (1996) estimated that older Americans with incomes below the federal poverty level spent 30 percent of their income out-of-pocket on health care, and those with incomes between 100 and 125 percent of the federal poverty level spent 31 percent of their income. These results were consistent with findings from earlier studies (see, for example, American Association of Retired Persons [AARP] 1995).

Prior estimates, however, have not given a complete picture of the impact of health care costs on lower-income older Americans, a population that includes two very distinct subgroups. One segment of the lower-income elderly is partially shielded from high health care costs because they receive Medicaid benefits. However, many others are not receiving Medicaid because they do not meet both the federal categorical requirements and state-defined income and asset requirements.² Others who do meet those eligibility requirements may decline to participate or may not realize that they are eligible for

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benefits. Lower-income elderly beneficiaries without such assistance would be expected to have higher out-of-pocket health care costs, on average, than those who are enrolled in Medicaid.

The release of Medicare Current Beneficiary Survey (MCBS) Cost and Use files has provided the opportunity to estimate out-of-pocket health spending for these two distinct subgroups. Prior studies projected out-of-pocket health spending using 1987 National Medical Expenditure Survey data, which did not have a sufficiently large sample of elderly persons to separate out lower-income Medicaid recipients from other lower-income elderly. This article uses projections from a simulation model that was largely built on the 1993 MCBS Cost and Use files to estimate out-of-pocket health spending in 1997 for these two subsets of lower-income elderly persons: the Medicaid and non-Medicaid populations.

Three issues are addressed: (1) the number of lower-income Medicare beneficiaries who did not receive Medicaid assistance in 1997, (2) estimated out-of-pocket health spending by these persons compared with that by other beneficiaries, and (3) possible factors that might account for high out-of-pocket health spending by poor Medicare beneficiaries without Medicaid. Out-of-pocket health spending includes Medicare deductibles and coinsurance; premiums for Medicare Part B, private insurance, and Medicare HMOs; payments for non-covered goods and services; and balance billing by physicians. Not included in this study are out-of-pocket payments for home care and nursing care services. In addition, the estimates do not include the health care costs of institutionalized populations (i.e., residents of nursing facilities and other institutions), or indirect tax payments toward health care financing (e.g., federal and state income taxes, property taxes, and hospital insurance taxes).

METHODOLOGY

The out-of-pocket health spending estimates were derived from a microsimulation model developed for AARP by The Lewin Group, Inc. The Medicare Benefits Simulation Model was designed to enable AARP to analyze the impact of Medicare policy changes on Medicare spending and on beneficiaries' out-of-pocket health spending. Model development involved updating data from the 1993 MCBS Cost and Use file to 1997 and beyond. When the model was developed, the 1993 file was the most recent, comprehensive database that contained individual Medicare beneficiaries' payments for health services.

The 1993 MCBS Cost and Use files offer several advantages over the 1987 National Medical Expenditure Survey (NMES), used in two previous studies for estimating out-of-pocket medical care costs of Medicare beneficiaries age 65 and older.³ First, the MCBS files provide more detailed information on current spending by older Medicare beneficiaries (i.e., those age 65 and older) and are based on actual Medicare claims data. Second, its sample of older Americans is more than triple the size of that in the NMES, making the MCBS more suitable for examining out-of-pocket spending trends by subgroups. Finally, because the MCBS data are more recent, the survey's use may improve the quality of the projections because it better captures the effects of changes in health markets and Medicare that took place between 1987 and 1993, such as the growth of managed care, increased Medicaid enrollment, and changes in Medicare payment policies.

The 1993 MCBS Cost and Use file includes survey data for approximately 12,000 Medicare beneficiaries, both those living in the community and those living in institutions. The survey collects information on utilization and expenditures for all health care services and sources of financing at three points during the year. In addition, the survey gathers information about an individual's socioeconomic status, health status, functional status, and insurance status. Respondents were matched to their actual Medicare claims, assuring the most accurate representation of Medicare payments.

The model trends forward 1993 MCBS data using actual and projected data from the following sources: the Health Care Financing Administration's (HCFA) Office of the Actuary (National Health Accounts and other unpublished data from HCFA's Office of Managed Care); the Congressional Budget Office; the Bureau of Census (Current Population Survey); and the Social Security Administration. In developing the projections from the MCBS, we attempted to capture the effects of (1) significant increases in enrollment to Medicare HMOs; (2) increased Medicaid enrollment; and (3) increases in the percentage of Medicare fee-for-service beneficiaries using each type of health service, as well as changes in their level of use of those services. Finally, we explicitly modeled Medicare cost-sharing provisions and beneficiary coverage from supplemental policies so that trends in out-of-pocket spending for these services would accurately reflect changes in Medicare cost-sharing requirements from 1993 to 1997.

The methodology projects that Medicare beneficiaries' average out-of-pocket spending on health care grew by 4.4 percent per year (in nominal terms) between 1993 and 1997. This compares to per capita growth in Medicare expenditures of approximately 9 percent and out-of-pocket spending

(excluding premium payments) for the entire population of one percent annually over the same period. At the same time, the 1997 estimate of average percentage of income spent out-of-pocket on health care was virtually unchanged from the 1993 figure.

While the microsimulation approach has numerous strengths, it is also important to understand that microsimulation modeling requires numerous assumptions, and that this article therefore provides estimates rather than actual historical spending. These assumptions range from the characteristics of new entrants into Medicare HMOs to the assumed rate of increase in out-of-pocket spending for non-Medicare services. Whenever possible, we based our assumptions on existing research. We note, however, that for some aspects of the projections it was necessary to use simplifying assumptions due to a lack of data. For example, data about the specific features of prescribed medication coverage for Medicare HMOs (e.g., coverage limits and copayments required) were not available. Therefore, we had to make reasonable assumptions about differing levels of prescribed medication coverage based on anecdotal evidence from news articles.

MEDICAID COVERAGE OF POOR AND NEAR-POOR MEDICARE BENEFICIARIES

An estimated 34.3 million persons age 65 and older living in the community⁴ were enrolled in the Medicare program in 1997. Because this figure includes beneficiaries who were enrolled for part of the year—that is, those who died or became eligible for enrollment during the year—it represents continuous enrollment rather than a point-in-time estimate.

We define poor beneficiaries as those with incomes below the federal poverty level.⁵ By this definition, we estimate that over 3.5 million Medicare beneficiaries age 65 and over were poor (Figure 1). In 1997, 42 percent of poor beneficiaries received assistance from Medicaid at some point during the year.⁶ Most of the remainder either purchased private Medigap policies (23 percent), had employer-sponsored coverage (11 percent), or were enrolled in HMOs (8 percent). Another 16 percent of poor beneficiaries were enrolled in fee-for-service Medicare and had no private or public supplemental insurance.

Almost 2.5 million older beneficiaries were near-poor; that is, had incomes between 100 and 125 percent of the federal poverty level (Figure 1). Approximately one out of every four near-poor beneficiaries received Medicaid assistance in 1997. One out of five were in fee-for-service Medicare

Figure 1: Distribution of Medicare Beneficiaries by Insurance Coverage and Income Level, 1997

	TOTAL¹ (in thousands)	Medicaid Enrollees		Not Medicaid-Enrolled	
		Full	Part	Medicare	Medicare
		Year	Year	HMO	Employer Insurance Only
Total Enrollment¹ (in thousands)	34,333	3,265	724	4,477	11,464
Income Level					
Poor (<i><100% of poverty</i>)	3,506	37%	5%	8%	23%
Near-Poor (<i>100–125% of poverty</i>)	2,447	23%	*	12%	28%
Low-Income (<i>126–200% of poverty</i>)	6,955	8%	*	13%	33%
Middle-Income (<i>201–400% of poverty</i>)	12,690	4%	2%	13%	29%
High-Income (<i>400%+ of poverty</i>)	8,735	3%	*	15%	26%

The insurance categories used are hierarchical categories based on the following order and definitions:

- *Full-Year Medicaid*: Medicare beneficiaries with Medicaid coverage for the entire period they are Medicare beneficiaries during the year. This time period could be less than 12 months for persons who became Medicare beneficiaries during the year or who died.
- *Part-Year Medicaid*: Medicare beneficiaries with Medicaid coverage for less than the entire period they are Medicare beneficiaries during the year.
- *HMO*: Medicare beneficiaries enrolled in a Medicare risk HMO for at least one month during the period they are Medicare beneficiaries during the year and not enrolled in Medicaid at any time during the year. Most HMOs participating in the Medicare program are risk HMOs. Medicare pays these plans a flat fee for each beneficiary enrolled in the plan regardless of the actual cost incurred in providing care to the beneficiary (HCFA, *Medicare Chartbook*, Baltimore, MD, 1996).
- *Free-for-Service*: Medicare beneficiaries not enrolled in Medicaid with individually purchased Medicaid supplemental insurance, employer-provided supplemental insurance, cost-based HMO coverage, or no supplemental coverage. Within this category any further classification is based on the following order: employer-provided insurance, individually purchased Medigap insurance, and Medicare only.

Note: Percentages are of row totals. They may not sum to 100% because of rounding.

¹ Non-institutionalized beneficiaries age 65 and older.

*Insufficient number of observations for presenting a statistically significant projection.

Source: Medicare Benefits Simulation Model.

with no supplemental coverage, and the remainder had private supplemental insurance or were enrolled in HMOs.

OUT-OF-POCKET HEALTH SPENDING BY POOR AND NEAR-POOR BENEFICIARIES

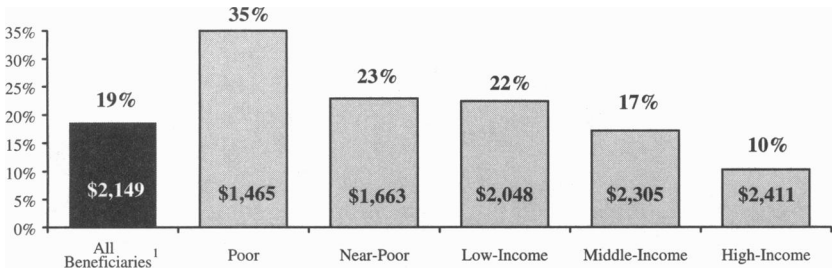
Out-of-pocket health care spending by poor and near-poor Medicare beneficiaries—even excluding home care and nursing facility costs—constitutes a substantial percentage of their income, on average. As shown in Figure 2, non-institutionalized Medicare beneficiaries age 65 and over were estimated to have spent an average of \$2,149, or 19 percent of income, out-of-pocket for health care in 1997.⁶ However, beneficiaries with incomes below the federal poverty level were estimated to have spent an average of \$1,465, or 35 percent of their income, out-of-pocket on health care.⁷ Near-poor beneficiaries were estimated to have spent an average of \$1,663, or 23 percent of their income, out-of-pocket for health care.

While the average percentage of income spent out-of-pocket on health-related costs for poor and near-poor beneficiaries is substantial, the estimates in Figure 2 mask the burden of out-of-pocket costs for the majority of lower-income beneficiaries, that is, the almost 60 percent of poor beneficiaries and over 75 percent of near-poor beneficiaries who did not receive Medicaid in 1997 (Figure 1).

Poor beneficiaries who did not receive Medicaid assistance were estimated to have spent, on average, about half of their income out-of-pocket for health care, compared to 8 percent of income for beneficiaries with full-year Medicaid coverage (Figure 3). This result was similar for both those beneficiaries in fee-for-service and those enrolled in HMOs. Poor HMO enrollees not receiving Medicaid were estimated to have spent, on average, 48 percent of their income on health care, compared to an average of 54 percent for those in fee-for-service.⁸

Near-poor beneficiaries who did not receive Medicaid assistance and who were in the traditional fee-for-service program spent an estimated 30 percent of their income out-of-pocket for health care, on average, compared to 4 percent for those with full-year Medicaid coverage. Those who were enrolled in HMOs spent, on average, 23 percent of their income—the same as for all near-poor beneficiaries.

Figure 2: Average 1997 Out-of-Pocket Cost Percentage for Medicare Beneficiaries, by Income Status

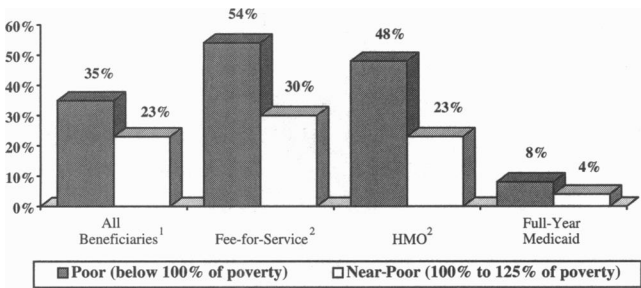


Income status definitions: poor=below poverty; near poor=100% to 125% of poverty; low-income=126% to 200% of poverty; middle-income=over 201% to 400% of poverty; high-income=over 400% of poverty. An individual's out-of-pocket health spending is capped at 100 percent of income.

¹Non-institutionalized beneficiaries age 65 and over.

Source: Medicare Benefits Simulation Model.

Figure 3: Average 1997 Out-of-Pocket Cost Percentage for Poor and Near-Poor Medicare Beneficiaries, by Insurance Type



An individual's out-of-pocket health spending is capped at 100 percent of income.

¹Non-institutionalized beneficiaries age 65 and over.

²Not enrolled in Medicaid.

Source: Medicare Benefits Simulation Model.

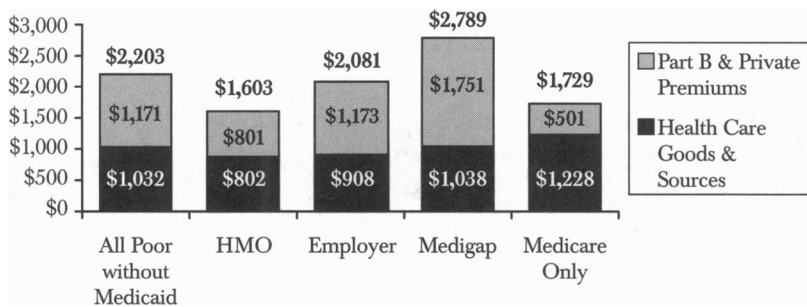
FACTORS CONTRIBUTING TO HIGH OUT-OF-POCKET HEALTH SPENDING BY POOR MEDICARE BENEFICIARIES WITHOUT MEDICAID

The particularly high level of out-of-pocket spending by those poor Medicare beneficiaries who do not receive Medicaid assistance warrants further

analysis. At first blush, it is somewhat surprising that poor Medicare HMO enrollees were estimated to have spent close to half their income, on average, out-of-pocket for health care, since the conventional wisdom is that beneficiaries lower their out-of-pocket health costs by joining Medicare HMOs. However, this high spending-to-income ratio can largely (although not entirely) be explained by the income levels of HMO enrollees. Poor HMO beneficiaries tend to have lower incomes than other poor beneficiaries, so even low levels of spending result in high spending-to-income ratios. Indeed, total out-of-pocket spending for poor HMO enrollees without Medicaid (\$1,603) is much lower than the average for all poor non-Medicaid beneficiaries (\$2,203; see Figure 4). Furthermore, Part B premiums alone are estimated to account for close to one-third of poor HMO beneficiaries' out-of-pocket health spending, and private insurance premiums account (including HMO premiums) for another 18 percent. Therefore, even if HMOs lower the costs of health care goods and services, the costs of Part B premiums and HMO premiums create a substantial financial burden for poor HMO enrollees.

Among poor non-Medicaid fee-for-service beneficiaries, there were substantial differences in out-of-pocket spending depending on whether they had private supplemental insurance or had no supplemental insurance ("Medicare-only"; see Figure 4). Most of this difference is due to the cost of supplemental insurance premiums. Those beneficiaries who purchased individual Medigap policies, in particular, had much higher premium costs than did those with employer-provided coverage (whose premiums were likely

Figure 4: Average 1997 Out-of-Pocket Spending by Poor Medicare Beneficiaries Without Medicaid



¹Non-institutionalized beneficiaries age 65 and older.

Source: Medicare Benefits Simulation Model.

subsidized by the current or previous employer) and HMO enrollees. It is possible that part of this premium increase reflects the differential health status of Medigap enrollees relative to other groups (since lower health status would be expected to be reflected in higher health costs and higher premiums). However, our data were not sufficient for testing this hypothesis.⁹

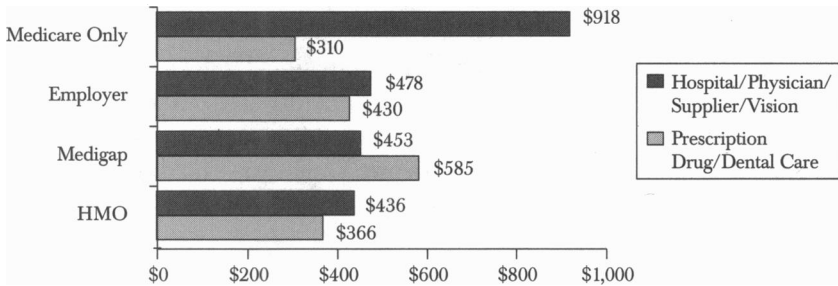
Figure 4 also shows that poor Medicare-only beneficiaries incurred somewhat higher out-of-pocket spending on health care goods and services than did the other groups. However, further analysis reveals that Medicare-only beneficiaries spent proportionately less on dental care and prescription drugs (which are not covered by Medicare) than did other poor non-Medicaid beneficiaries, suggesting a potential difficulty in paying for these goods and services. Poor Medicare-only beneficiaries were estimated to have spent only \$310 out-of-pocket for prescription drugs and dental care (see Figure 5). By contrast, poor HMO enrollees were estimated to have spent an average of \$366 for drugs and dental care; those with employer-provided coverage spent an estimated \$430, and those with Medigap coverage spent an estimated \$585. While it is theoretically possible that poor Medicare-only beneficiaries had less need for prescription drugs than other poor beneficiaries, this seems unlikely given other evidence that Medicare-only beneficiaries tend to delay or to go without care due to cost.¹⁰

DISCUSSION

Over the next several months and years, policymakers and policy advocates will be suggesting reforms to the Medicare program with the intent of enabling it to finance the health care needs of the baby boom population. Some proposals they may consider involve changing out-of-pocket costs to beneficiaries, raising beneficiary premiums, changing Medicare's cost-sharing structure, expanding prescription drug coverage, or linking premiums to beneficiary income levels.

Our estimates show that, while Medicaid provides substantial financial protections for some Medicare beneficiaries, the majority of poor and near-poor beneficiaries do not receive these protections. As a result, many lower-income non-Medicaid beneficiaries are paying substantial shares of their incomes out-of-pocket for health care. While our data do not allow us to determine whether they are delaying or forgoing needed care due to an inability to pay, the low levels of prescription drug and dental care spending by poor Medicare-only beneficiaries is an indicator that such problems may indeed be occurring.

Figure 5: Average 1997 Out-of-Pocket Spending by Poor Medicare Beneficiaries Without Medicaid, by Type of Insurance



¹Non-institutionalized beneficiaries age 65 and older.

Source: Medicare Benefits Simulation Model.

Our analysis does not suggest a level of out-of-pocket health spending that is “too high.” However, it is important to understand the magnitude of the out-of-pocket burden, particularly for lower-income households whose older members do not receive Medicaid. Furthermore, it is important to underscore that the estimates reported here do not include the costs of home care and nursing care services, which may increase out-of-pocket burdens, particularly for the oldest beneficiaries.

As policymakers assess changes that will affect Medicare beneficiaries’ out-of-pocket burdens, it is also important to keep in mind how changes in Medicare enacted by the Balanced Budget Act of 1997 will affect out-of-pocket health spending. Most significantly, beneficiaries will be paying substantially higher Part B premiums over the next several years. Not only will Part B premiums be keeping pace with the growth in Part B costs (which typically grow faster than Social Security payments), but beneficiaries will also be responsible for covering a greater share of home health costs through the Part B premium (O’Sullivan et al. 1997). As a result, beneficiary premiums will consume an even greater share of income for most beneficiaries in the future than they did in 1997. Alternatively, out-of-pocket costs may fall somewhat due to greater coverage for some preventive services, such as diabetes self-management, mammography, pap smears, and prostate and colorectal cancer screening.

Medicare was created in order to assure that older Americans had access to health care regardless of their incomes. The estimates presented in this study suggest that, for many lower-income beneficiaries, obtaining

health care is creating a substantial financial burden. Rather than imposing additional costs on this population, Congress should consider increasing effective financial protections to lower-income Medicare beneficiaries. In addition, further research should assess the impact that high out-of-pocket costs have on health care utilization for this population. Useful analyses would assess the impact of health status on health care utilization and out-of-pocket health care costs. Further research might shed light on the extent to which poor and near-poor beneficiaries are reducing their use of health services because of an inability to pay for them.¹¹

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NOTES

1. Medicare cost-sharing requirements include an inpatient hospital deductible (\$760 per benefit period in 1997); hospital coinsurance after the 60th day of care each benefit period; skilled nursing facility coinsurance; a Part B deductible (\$100 per year); and 20 percent coinsurance for Part B services. Beneficiaries who have supplemental insurance (either employer-provided or Medigap) typically have coverage for some or all of these cost-sharing requirements. Beneficiaries enrolled in health maintenance organizations (HMOs) also typically have lower cost sharing than do those in the traditional Medicare program. They may also receive additional benefits, such as outpatient prescription drug coverage and physician exams (Health Care Financing Administration [HCFA]. *Your Medicare Handbook 1997*, Baltimore, MD 1997).
2. Income thresholds are typically below the poverty level. At their option, states may expand financial thresholds up to 100 percent of the federal poverty level for elderly and disabled persons. States can also provide Medicaid coverage for the "medically needy"—those individuals whose high medical expenses substantially reduce their financial thresholds (Lamphere et al. 1997). In addition, some beneficiaries not otherwise eligible for Medicaid can receive Medicaid assistance under the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Beneficiary (SLMB) programs. Under QMB provisions, state Medicaid programs pay Medicare premiums and cost sharing for persons with incomes below the

poverty line (who do not receive other Medicaid benefits). Under SLMB, state Medicaid programs pay for Part B premiums for enrolled beneficiaries with income between 100 percent and 120 percent of poverty. Participation in these programs is low; some analysts have speculated that this is due to poor outreach by states, complex enrollment processes, and a reluctance by some beneficiaries to participate in what they perceive to be a welfare program (Moon, Kuntz, and Pounder 1996; Nemore 1997; Families USA 1998).

3. AARP 1995; Moon, Kuntz, and Pounder 1996.
4. That is, beneficiaries who did not reside in an institution at some point during the year.
5. The 1997 poverty levels (\$7,755 for individuals and \$9,780 for couples age 65 and older) were projected from 1993 U.S. Census Bureau estimates by adjusting those estimates for inflation as measured by the Consumer Price Index (CPI-U). Census Bureau estimates of the poverty level for 1997 were not available for this analysis.
6. This includes beneficiaries who received assistance through the QMB and SLMB programs.
7. The average spending-to-income ratio is computed as the average of each beneficiary's spending-to-income ratio. It is *not* calculated as the average health spending divided by average income. Income is defined as the beneficiary's share of household spending. We capped individual out-of-pocket health spending at 100 percent of income. See Gross et al. (1997) for a more detailed analysis of the derivation of these estimates.
8. This estimate is roughly comparable to Moon, Kuntz, and Pounder's (1996) estimate of 31 percent for 1996, which included home care costs but excluded nursing care costs.
9. The estimated average percentage of income spent out-of-pocket on health care by poor beneficiaries would have been even higher had we not imposed the assumption that beneficiaries do not spend more than 100 percent of their income out-of-pocket for health care in a given year. Many poor, non-Medicaid beneficiaries reported out-of-pocket spending that exceeded their income. However, including their actual reported spending would have skewed the average spending-to-income ratio upward; capping brings the distribution closer to a normal distribution. Indeed, the average is relatively close to the median spending-to-income ratio of 45 percent of income for poor, non-Medicaid beneficiaries.
10. Our data do reveal that poor Medigap enrollees are more likely to be over age 85 and less likely to be under age 75 than are other poor non-Medicaid beneficiaries. Since age is correlated with increased health care utilization, we would expect that, on average, poor Medigap enrollees use more health services than do other poor beneficiaries. To the extent that this is true, it would help to explain some of the high cost of Medigap premiums, many of which are not community-rated.
11. Rowland (1998), citing analysis of MCBS data by the Medical Payment Advisory Commission, noted that beneficiaries with Medicare-only coverage are less likely than those with private or Medicaid supplemental insurance to have a usual

source of care, are more likely to delay care due to cost, and are less likely to have a physician visit than are other beneficiaries.

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